Wheeler | Innovative Care. Positive Change.

AUTHORIZATION TO DISCLOSE / OBTAIN / ACCESS INFORMATION

_____ _____ _____

Print Client/Student Name *Date of Birth* *Client Number*

I hereby authorize Wheeler Clinic and its staff to: (check one or both)

☐ **DISCLOSE** (share/send/allow access to) information about me and my medical/service/educational records
☐ **OBTAIN** (receive/request/obtain access to) information about me and my medical/service/educational records

TO/FROM: Name and Address of third-party organization or individual:

Name:_____Phone: _____

Street Address: _____ City: _____State:_____ Zip: _____

The information that is obtained/disclosed/accessed might include my service, treatment and/or educational information related to my diagnosis or treatment of my psychiatric disabilities, substance abuse disabilities, medical/dental conditions, or my genetic or HIV-related information. The information may be obtained/disclosed in verbal, written and/or electronic format.

The **PURPOSE(S)** of this disclosure is/are as follows:

☐ Treatment planning, communication, coordination
☐ Discharge planning and referral
☐ Court-related or legal
☐ Disability determination or re-determination
☐ Educational/IEP Planning
☐ At request of individual (no statement of purpose necessary)
☐ Other (specify): _____

OPTIONAL SECTION: Please describe any information which you would like Wheeler Clinic to NOT disclose about you:

I understand that:

- Under the applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus may not be protected by federal privacy regulations.
- I may revoke this authorization in writing at any time by contacting the Wheeler Clinic Records Room at (860) 793-3843, except that it will not have any effect on actions taken by Wheeler Clinic or the recipient organization before it received my written revocation/restriction request.
- I may receive a copy to inspect the information to be used or disclosed by this authorization.
- I may refuse to sign this form and that my refusal to sign this authorization will not jeopardize the right to obtain present or future treatment.
- Confidential HIV-related information that may be disclosed includes whether the client has been counseled regarding HIV, has been the subject of an HIV test, or has HIV, HIV-related illness or AIDS, and also could include information that identifies or reasonably could identify the client as having one or more of such conditions, including information pertaining to the client's spouse, sexual partner, or person with whom the client shared needles or syringes.
- **If the client is a minor (age 17 and under), any disclosure of drug and alcohol abuse records, outpatient mental health records for treatment provided with the minor's consent only under 19a-14c, and/or HIV-AIDS- related information requires the signature of the minor client below. Without such signature, Wheeler Clinic will not disclose such records or information to the third party named above.**

This authorization shall **expire on (date)_____** or **6 months after date of signature** if no date is specified.

By signing below, I acknowledge that I have read and understand this authorization. My signature below serves as attestation to the fact that I am the client, or I am the legal guardian of the child whose health information I am authorizing disclosure of.

_____ _____ _____

Signature of client *Date* *Phone number of person signing*

_____ _____

Signature of parent/guardian *Date*

If signed by other than client, print name _____and check relationship below:

☐ Parent ☐ Guardian ☐ Conservator ☐ Power of Attorney ☐Other _____

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NOTICES

HIV/AIDS-related information

In the event that information released constitutes confidential HIV-related information protected under Connecticut law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Psychiatric or Social Work Records and Communications

In the event that information released constitutes privileged psychiatrist-patient, psychologist-patient, or social worker-patient communications:

The confidentiality of this record is required under chapter 899 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes.

Drug and Alcohol Abuse Records

In the event that information released is protected by the federal Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.